

DIETARY

Child: _____ **D.O.B.** ___/___/___ **Class #** _____ **Date** _____

Why is food restriction needed? Mark one.

- Food restriction for religious reason. List food(s): _____
Substitute with any other food from the same food component. *
(Skip to bottom for parent signature)
- Food restriction due to allergy or intolerance. List food(s): _____
(Be specific. Specify if food item omitted is only that item or anything with that item in it. (Example: tomatoes or tomato products)
Substitute with another food item from the same food component unless otherwise specified here:* _____

- Food Additive Needed. List food(s): _____

CB ONLY:

If substitute food must be from another food component or an additive needed, a physician's signature is needed. Obtain Auth. For Release of Medical (Dietary) Plan and forward to the Site Supervisor for mailing.

* If food restriction is for milk, IL. State Board of Education Child and Adult Food Program requirements state that fluid food substitution must be nutritional equivalent to milk.

***Has allergy/intolerance been diagnosed by a physician? Yes No**

***If yes, list physician's information below and obtain *Authorization for Release of Medical Plan*. Forward this and the release to the Site Supervisor for mailing.**

_____	_____
(physician name)	(phone #)
_____	_____
(address)	(city, state, zip)

***If no, indicate why restriction is requested including symptoms or reactions child has if food is eaten:** _____

I give permission for PACT staff to carry out instructions above and *Dietary form Physician* (if needed) when my child is at PACT activities and for PACT to post my child's allergy/intolerance in the classroom so that all are aware.

(Parent Signature)

(Date)

Teacher signature _____ **Date reviewed** _____

FA: Give original to CBT for Health & Safety Notebook in Classroom / FA: Email to Health Coord. / FA: Give copy to Cook
HBT: Email to Health Coord. & place original in Health & Safety Notebook